FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034694

Facility Name: Oakbrook Healthcare Centre

Address: 2013 Midwest Road (Number) Oakbrook (City) 60523 (Zip Code)

County: DuPage

Telephone Number: (630) 495-0220 **Fax #** (630) 495-9150

HFS ID Number: 36-3601135-001

Date of Initial License for Current Owners: 09/07/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-05 to 31-Dec-05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ March 31, 2006 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,033	6,687	7,857	29,577	8
9	SNF/PED					9
10	ICF	15,615	9,069	134	24,818	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,648	15,756	7,991	54,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.53%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started September 7, 1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date October 26, 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 6,392

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	364,923	30,960	11,404	407,287		407,287		407,287			1
2	Food Purchase		261,990		261,990	(11,162)	250,828	(689)	250,139			2
3	Housekeeping	390,992	80,042		471,034		471,034		471,034			3
4	Laundry	59,564	27,263	4,807	91,634		91,634		91,634			4
5	Heat and Other Utilities			180,940	180,940		180,940		180,940			5
6	Maintenance	87,517	25,057	79,804	192,378		192,378		192,378			6
7	Other (specify):*											7
8	**TOTAL General Services**	902,996	425,312	276,955	1,605,263	(11,162)	1,594,101	(689)	1,593,412			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,931,194	240,799	5,584	3,177,577		3,177,577		3,177,577			10
10a	Therapy			237	237		237		237			10a
11	Activities	174,128	28,668		202,796		202,796		202,796			11
12	Social Services	56,549		4,800	61,349		61,349		61,349			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,161,871	269,467	27,121	3,458,459		3,458,459		3,458,459			16
	C. General Administration											
17	Administrative	96,279		248,976	345,255		345,255	(170,779)	174,476			17
18	Directors Fees											18
19	Professional Services			47,948	47,948		47,948	21,837	69,785			19
20	Dues, Fees, Subscriptions & Promotions			38,725	38,725		38,725	(20,371)	18,354			20
21	Clerical & General Office Expenses	115,329	49,729	54,592	219,650		219,650	47,346	266,996			21
22	Employee Benefits & Payroll Taxes			656,278	656,278	11,162	667,440	45,911	713,351			22
23	Inservice Training & Education							1,010	1,010			23
24	Travel and Seminar			5,419	5,419		5,419	4,336	9,755			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			7,346	7,346		7,346	40,081	47,427			26
27	Other (specify):* *Payroll Taxes (Sch VII)*							13,303	13,303			27
28	**TOTAL General Administration**	211,608	49,729	1,059,284	1,320,621	11,162	1,331,783	(17,326)	1,314,457			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,276,475	744,508	1,363,360	6,384,343		6,384,343	(18,015)	6,366,328			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakbrook Healthcare Centre #0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,959	72,959		72,959	303,209	376,168			30
31	Amortization of Pre-Op. & Org.							494	494			31
32	Interest			288,000	288,000		288,000	400,942	688,942			32
33	Real Estate Taxes			70,596	70,596		70,596		70,596			33
34	Rent-Facility & Grounds			1,762,782	1,762,782		1,762,782	(1,760,000)	2,782			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,194,337	2,194,337		2,194,337	(1,055,355)	1,138,982			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		270,285	576,100	846,385		846,385		846,385			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		270,285	661,510	931,795		931,795		931,795			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,276,475	1,014,793	4,219,207	9,510,475		9,510,475	(1,073,370)	8,437,105			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128,510	30		9
10	Interest and Other Investment Income	(25,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(689)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,165)	24		19
20	Contributions	(172)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,514)	21		24
25	Fund Raising, Advertising and Promotional	(43,825)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	5,000	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(86)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 25,369		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,098,739)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,098,739)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,073,370)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-05

Ending: 31-Dec-05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(689)	0	0	0	0	0	0	0	0	0	0	(689)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(689)	0	0	0	0	0	0	0	0	0	0	(689)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(170,779)	0	0	0	0	0	0	0	0	0	(170,779)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,137	6,700	0	0	0	0	0	0	0	0	21,837	19
20	Fees, Subscriptions & Promotions	(44,083)	23,712	0	0	0	0	0	0	0	0	0	(20,371)	20
21	Clerical & General Office Expenses	(30,514)	72,860	5,000	0	0	0	0	0	0	0	0	47,346	21
22	Employee Benefits & Payroll Taxes	0	45,911	0	0	0	0	0	0	0	0	0	45,911	22
23	Inservice Training & Education	0	1,010	0	0	0	0	0	0	0	0	0	1,010	23
24	Travel and Seminar	(2,165)	6,501	0	0	0	0	0	0	0	0	0	4,336	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	40,081	0	0	0	0	0	0	0	0	40,081	26
27	Other (specify):*	0	13,303	0	0	0	0	0	0	0	0	0	13,303	27
28	**TOTAL General Administration**	(76,762)	7,655	51,781	0	0	0	0	0	0	0	0	(17,326)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,451)	7,655	51,781	0	0	0	0	0	0	0	0	(18,015)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	128,510	470	174,229	0	0	0	0	0	0	0	0	303,209	30
31	Amortization of Pre-Op. & Org.	0	0	494	0	0	0	0	0	0	0	0	494	31
32	Interest	(25,690)	51,333	375,299	0	0	0	0	0	0	0	0	400,942	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,760,000)	0	0	0	0	0	0	0	0	(1,760,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	102,820	51,803	(1,209,978)	0	0	0	0	0	0	0	0	(1,055,355)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	25,369	59,458	(1,158,197)	0	0	0	0	0	0	0	0	(1,073,370)	45

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 43,704	$ 43,704	1
2	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	13,303	13,303	2
3	V	17	Management Fee Income	248,976	Lancaster, Ltd.	100.00%		(248,976)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	15,137	15,137	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	72,860	72,860	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	45,911	45,911	6
7	V	24	Seminars & Travel		Lancaster, Ltd.	100.00%	6,501	6,501	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	34,493	34,493	8
9	V	20	Marketing and Fees		Lancaster, Ltd.	100.00%	22,586	22,586	9
10	V	32	Interest		Lancaster, Ltd.	100.00%	51,333	51,333	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	470	470	11
12	V	20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,126	1,126	12
13	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	1,010	1,010	13
14	Total			$ 248,976			$ 308,434	$ * 59,458	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		34	Rental	$ 1,760,000	OakBrook Associates	100.00%	$	$ (1,760,000)	15
16	V		32	Interest	30,293	OakBrook Associates	100.00%	405,592	375,299	16
17	V		30	Depreciation		OakBrook Associates	100.00%	174,229	174,229	17
18	V		31	Amortization		OakBrook Associates	100.00%	494	494	18
19	V		26	Mortgage Insurance Premium		OakBrook Associates	100.00%	40,081	40,081	19
20	V		19	Accounting Fees		OakBrook Associates	100.00%	6,700	6,700	20
21	V		21	State Replacement Tax		OakBrook Associates	100.00%	5,000	5,000	21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 1,790,293			$ 632,096	$ * (1,158,197)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	33.33	See Attached	2	4.17	Lancaster	$ 8,750	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	See Attached	5	10.42	Lancaster	17,477	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.00	See Attached	5	10.42	Lancaster	17,477	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,704		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 478-3699
Fax Number: (773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	2	$ 8,750	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		2	398	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	5	17,477	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		5	931	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	5	17,477	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		5	931	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		248,976	15,137	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	248,976	72,860	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		248,976	45,911	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		248,976	6,501	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	248,976	34,493	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	248,976	22,586	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		248,976	(851)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		248,976	470	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		248,976	1,126	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		248,976	11,043	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		248,976	1,010	23
24	32	*Direct Interest*							52,184	24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 308,434	25

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Reality Capital		X	Mortgage	$48,866.91	11/1/98	$ 8,152,700	$	11/30/34		$ 405,592	1
2												2
3	HUD		X	Replacement Reserve Deposit							(3,799)	3
4												4
5												5
	Working Capital											
6	Harston Investments		X	Working Capital							288,000	6
7	JP Morgan Chase Bank		X	Working Capital							(851)	7
8												8
9	TOTAL Facility Related				$48,866.91		$ 8,152,700	$			$ 688,942	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,152,700	$			$ 688,942	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 40,081 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 62,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 65,096	2
3. Under or (over) accrual (line 2 minus line 1).	$ 2,596	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 68,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 70,596	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	58,818	8
2001	60,491	9
2002	62,409	10
2003	61,107	11
2004	65,096	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakbrook Healthcare Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0034694

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-22-303-035	Long-Term Healthcare	$ 65,096.36	$ 65,096.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,096.36	$ 65,096.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: $ 234,464 / $ 17,275
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 494
4. Dates Incurred: 26-Oct-98 / Jan 2005

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1998	$ 830,000	1
2					2
3	TOTALS			$ 830,000	3

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$ 3,586,000	$ 91,949	40	$ 179,300	$ 87,351	$ 955,500	4
5			1992	1994	1,863,459	59,157	35	53,242	(5,915)	726,162	5
6			1994		25,000	642	35	714	72	8,143	6
7											7
8											8
	Improvement Type**										
9	Various			1988	8,828	286	20	179	(107)	8,142	9
10	Various			1989	92,298	3,426	20	4,684	1,258	76,742	10
11	Various			1990	24,448	595	20	1,166	571	17,226	11
12	Various			1991	2,212	70	15	111	41	1,328	12
13	Various			1992	1,275,149	40,483	20	65,479	24,996	795,151	13
14	Various			1993	287,139	6,201	15	12,111	5,910	165,333	14
15	Various			1994	12,341	317	15	618	301	5,615	15
16	Various			1995	52,918	473	15	923	450	16,032	16
17	Room #112 Remodeling			1996	2,285	59	15	114	55	1,085	17
18	Nurses' Call Station			1996	10,545	270	15	527	257	4,662	18
19	Ceramic Tiled Bathroom and Tub Room			1996	15,362	394	20	768	374	6,858	19
20	Rehab Room			1997	31,848	817	15	1,592	775	13,420	20
21	Fire Doors			1997	3,013	77	15	151	74	1,272	21
22	Physical Therapy Room			1997	6,749	173	15	337	164	2,841	22
23	12 Bathrooms Vented			1997	8,670	222	15	434	212	3,549	23
24	Roof Improvements			1997	7,150	183	15	358	175	2,868	24
25	Excelon Vinyl Tiles-1st Floor			1997	15,600	400	15	780	380	6,055	25
26	Excelon Vinyl Tiles-1st Floor			1998	6,204	159	15	310	151	2,329	26
27	New Roof			1998	3,850	99	15	193	94	1,106	27
28	Custom Cabinets			1998	3,285	84	15	164	80	940	28
29	Fire Alarm Switch			1998	6,996	179	15	350	171	1,959	29
30	3 Shower Rooms Rehab			1999	15,560	399	15	778	379	4,226	30
31	Hot Water Heater			1999	7,269	186	15	363	177	1,894	31
32	Parking Lot Asphalt			1999	28,900	741	15	1,445	704	7,663	32
33	Rehab Resident Rooms			1999	17,825	457	15	891	434	4,649	33
34	Aquarium			2001	4,441	114	15	114		537	34
35	Picture Window			2001	14,403	369	15	369		1,707	35
36	Wander Guard System			2001	17,385	1,552	15	1,552		13,507	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet-Bookkeeping & Lounge	2001	$ 2,715	$ 70	15	$ 70	$	$ 324	37
38	Vinyl Tiles Hallway	2001	9,815	252	15	252		1,061	38
39	Auto Door	2002	2,340	60	15	117	57	429	39
40	Concrete Patio	2003	10,250	438	15	683	245	1,537	40
41	Three Concrete Pads W/Rails	2005	12,073	116	15	503	387	503	41
42	Construction of Town Square	2005	108,391	1,972	15	1,969	(3)	1,969	42
43	Fittings & Fixtures for Town Square	2005	83,613	11,948	15	6,271	(5,677)	6,271	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,686,329	$ 225,389		$ 339,982	$ 114,593	$ 2,870,595	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 339,315	$ 11,587	$ 26,491	$ 14,904	10	$ 227,971	71
72	Current Year Purchases	64,664	9,240	4,572	(4,668)	10	4,572	72
73	Fully Depreciated Assets	577,650	972	4,653	3,681	10	577,650	73
74	**Lancaster Allocation***		470	470				74
75	TOTALS	$ 981,629	$ 22,269	$ 36,186	$ 13,917		$ 810,193	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,497,958	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 247,658	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 376,168	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 128,510	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,680,788	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		**Off-site Public Storage Space**			2,782			5
6								6
7	TOTAL				$ 2,782 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 218,120	$		$ 218,120	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			32,251			32,251	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			281,035			281,035	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				193,337		193,337	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	*Inhalation Therapy Other (specify): Med Sup/Bed Rent	39-3 39-2				44,694	76,948		44,694 76,948	13
14	TOTAL			$		$ 576,100	$ 270,285		$ 846,385	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (95,273)	$ 1,118,420	1
2	Cash-Patient Deposits	27,794	27,794	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,517,524	1,517,524	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,025	58,886	6
7	Other Prepaid Expenses	37,046	473,532	7
8	Accounts Receivable (owners or related parties)	1,018,221	1,018,221	8
9	Other(specify): Employee Advances	7,987	7,987	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,560,324	$ 4,222,364	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		830,000	13
14	Buildings, at Historical Cost		3,586,000	14
15	Leasehold Improvements, at Historical Cost	1,971,627	4,052,090	15
16	Equipment, at Historical Cost	780,875	961,441	16
17	Accumulated Depreciation (book methods)	(1,546,717)	(3,182,143)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(259,910)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,205,785	$ 6,263,675	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,766,109	$ 10,486,039	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,028	$ 461,522	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,096	33,096	28
29	Short-Term Notes Payable		95,596	29
30	Accrued Salaries Payable	437,811	437,811	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,409	16,409	31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,000	68,000	32
33	Accrued Interest Payable		33,623	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 987,344	$ 1,146,057	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,893,879	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,400,000	$ 10,293,879	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,387,344	$ 11,439,936	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 378,765	$ (953,897)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,766,109	$ 10,486,039	48

***(See instructions.)**

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (252,971)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (252,971)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	631,736	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 631,736	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 378,765	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,483,830)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,483,830)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,789,933	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,260,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 529,933	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (953,897)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,015,178	1
2	Discounts and Allowances for all Levels	(1,697,645)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,317,533	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,475,856	6
7	Oxygen	32,875	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,508,731	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	201,566	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,217	19
20	Radiology and X-Ray	19,826	20
21	Other Medical Services	58,098	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 287,707	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,840	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	2,400	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,400	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,142,211	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,605,263	31
32	Health Care	3,458,459	32
33	General Administration	1,320,621	33
	B. Capital Expense		
34	Ownership	2,194,337	34
	C. Ancillary Expense		
35	Special Cost Centers	846,385	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,510,475	40
41	**Income before Income Taxes (line 30 minus line 40)****	631,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 631,736	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Tax Return not yet prepared****

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,045	2,190	$ 87,092	$ 39.77	1
2	Assistant Director of Nursing	1,981	2,278	65,742	28.86	2
3	Registered Nurses	47,846	51,128	1,374,714	26.89	3
4	Licensed Practical Nurses	5,403	5,856	129,716	22.15	4
5	CNAs & Orderlies	106,865	115,371	1,239,395	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,945	2,366	40,718	17.21	9
10	Activity Assistants	12,614	13,710	133,410	9.73	10
11	Social Service Workers	1,981	2,182	56,549	25.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,513	33,857	364,923	10.78	15
16	Dishwashers					16
17	Maintenance Workers	5,623	6,212	87,517	14.09	17
18	Housekeepers	36,180	39,733	390,992	9.84	18
19	Laundry	5,566	6,323	59,564	9.42	19
20	Administrator	2,013	2,194	96,279	43.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,870	9,651	115,329	11.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,837	2,102	34,535	16.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	271,282	295,153	$ 4,276,475 *	$ 14.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	285	$ 11,404	1-3	35
36	Medical Director	412	16,500	9-3	36
37	Medical Records Consultant	107	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	5	140	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	97	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	127	4,800	12-3	45
46	Other(specify) Dementia Consultant	39	1,360	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	978	$ 38,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joanne Bedrosian	Administrator	N/A	$ 96,279
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,279

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd	$ 248,976
TOTAL (agree to Schedule V, line 17, col. 3)	$ 248,976
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone, Pogrund & Kkorey	Legal	$ 15,753
Myers Miller & Krouskopf	Legal	10,982
William E Lasko	Legal	2,825
Frost Ruttenberg & Rothblatt	Accounting	1,685
Richard Peelo	Accounting	2,250
Health Data Systems	Data Processing	6,057
Accu-Med Services, Inc	Data Processing	3,000
Ehealth Data Solutions	Data Processing	2,970
Personnel Planners	Payroll Tax Consultant	2,426
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,948

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,802
Unemployment Compensation Insurance	69,552
FICA Taxes	319,483
Employee Health Insurance	172,670
Employee Meals	11,162
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	9,681
Uniforms	6,206
Employment Fees	8,884
Lancaster Allocation	45,911
TOTAL (agree to Schedule V, line 22, col.8)	$ 713,351

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	30
Health Care Worker Background Check	12,662
(Indicate # of checks performed 1055)	
Promotional Advertising	20,371
Dues & Subscriptions	1,839
Licenses and Fees	3,623
Lancaster allocation	23,712
Less: Public Relations Expense	(23,712)
Non-allowable advertising	(20,285)
Yellow page advertising	(86)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,354

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,122
Seminar Expense	4,297
Lancaster Allocation	6,501
Entertainment Expense	(2,165)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,755

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,271** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,162** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.